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# APPLICATION FORM

## Steps to take:

1. Read the information package.
2. Fill out all fields in order for your referral to be processed.
3. You will be contacted by Intake Staff within one week. Please ensure your contact information is accurate.

## Admission Criteria

- Willing to live in a community setting in a semi-structured recovery-centered residential program.
- Stability for residence in a non-medical setting.
- Expected to provide a substance-free urine screen upon arriving at Karis and before admission. Applicants that require medical withdrawal will be required to do so before entry.
- Active participation is an essential requirement of programming.

If applying for the Parenting Program

- The Program can facilitate children up to the age of two-and-a-half years old.

What program are you applying for?  Non-Parenting at Karis Program  
 Parenting at Karis Program

## Participant Information

First Name: \_\_\_\_\_ Middle Name: \_\_\_\_\_ Last Name: \_\_\_\_\_

Preferred Name: \_\_\_\_\_ Preferred Pronoun: \_\_\_\_\_ Marital Status: \_\_\_\_\_

Is the applicant experiencing homelessness?  Yes  No

If No, then please provide:

Address: \_\_\_\_\_

City: \_\_\_\_\_ Postal Code: \_\_\_\_\_

Phone: \_\_\_\_\_ Email: \_\_\_\_\_

Care Card # \_\_\_\_\_ DOB: \_\_\_\_\_ SIN \_\_\_\_\_

## Referral Information

Date: \_\_\_\_\_ Referring Agent: \_\_\_\_\_

Agency Name: \_\_\_\_\_

Email: \_\_\_\_\_

Address: \_\_\_\_\_

Agency Phone: \_\_\_\_\_ Agency Fax: \_\_\_\_\_

Does client have access to BC ID and birth certificate? \_\_\_\_\_  
 Has client previously filed a Housing Registry application through BC Housing? \_\_\_\_\_

**Income Source**

- INCOME ASSISTANCE \_\_\_\_\_
- PERSONS WITH DISABILITIES (PWD) \_\_\_\_\_
- PERSON OF MULTIPLE BARRIERS \_\_\_\_\_
- CHILD TAX CREDIT \_\_\_\_\_
- CPP \_\_\_\_\_
- OTHER \_\_\_\_\_

**Current Treatment (If Relevant)**

Name of center: \_\_\_\_\_  
 Address of center: \_\_\_\_\_  
 Phone number: \_\_\_\_\_  
 Client start date and discharge date: \_\_\_\_\_  
 Support person (if applicable): \_\_\_\_\_  
 Support person contact: \_\_\_\_\_

**History of Substance Misuse Concerns**

TYPE	AGE OF FIRST USE	HOW OFTEN USED (Daily / weekly / monthly)	AMOUNT / QUANTITY	DATE LAST USED (Month / day / year)
<b>ALCOHOL</b> BEER / WINE / HARD LIQUOR				
<b>CANNABIS</b> POT / HASH				
<b>COCAINE</b> COKE				
<b>CRACK COCAINE</b>				
<b>HALLUCINOGEN</b> ACID / MUSHROOMS / PCP / KETAMINE				

<b>BARBITURATE</b> PHENNIES / YELLOW JACKETS				
<b>AMPHETAMINE</b> CRYSTAL METH / ECSTASY / SPEED				
<b>HEROIN</b> CHINA WHITE / CRANK				
<b>OPIATE</b> MORPHINE / CODEINE / OPIUM				
<b>INHALANT</b> GLUE / HAIRSPRAY				
<b>ILLICIT METHADOSE</b>				
<b>BENZODIAZEPINE</b> SLEEPING PILLS / TRANQUILIZERS				
<b>OVER THE COUNTER DRUGS</b> COUGH SYRUP				
<b>OTHER PRESCRIPTION DRUGS</b> T3s / VALIUM				
<b>TOBACCO</b>				
<b>FENTANYL</b>				
<b>OTHER</b>				

### Dependent Information

Is the applicant currently pregnant? YES  NO

If yes, when is the due date? \_\_\_\_\_

Does the applicant have MCFD involvement? YES  NO

If yes, name of social worker? \_\_\_\_\_ Phone number: \_\_\_\_\_

In what city does this applicant have an open ministry file? \_\_\_\_\_

### Children's Information:

Please list all children in and out of your care.

CHILDS NAME	DATE OF BIRTH	IN APPLICANTS CARE.
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		YES OR NO.

## Medical History

Allergies to Medication: \_\_\_\_\_

Does the applicant have a BC medical/service card number?  YES  NO

Family Physician: \_\_\_\_\_ Telephone: \_\_\_\_\_

Any current health concerns (e.g. Diabetes, High cholesterol):

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Does the applicant have any dietary restrictions (e.g. lactose intolerant, celiac)?  YES  NO

If Y, please explain: \_\_\_\_\_

In order for Karis to provide special dietary requirements, a doctor's note must be supplied.

Has Applicant been hospitalized in the last 30 days:  YES  NO

Reason:

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MEDICATION	DOSAGE	REASON PRESCRIBED

Is the applicant on current harm reduction therapy?  YES  NO

Type \_\_\_\_\_

Who is the applicant's prescribing doctor? \_\_\_\_\_

Start date: \_\_\_\_\_ Dosage: \_\_\_\_\_

Has the applicant had a diagnosis of any of the following?

- ADHD
- FASD
- Borderline Personality Disorder (BPD)
- Autism Spectrum
- Schizophrenia
- Bipolar Disorder
- Eating Disorder
- Seizures
- Head Injuries
- PTSD
- Other \_\_\_\_\_

What are the impacts on daily life? Please explain: \_\_\_\_\_

Has the applicant been hospitalized for mental health concerns in the past 6 months?

- YES  NO

Dates: \_\_\_\_\_

Reasons: \_\_\_\_\_

Does the applicant experience any limits to mobility?  YES  NO

If yes, are they in need of additional supports/accommodations? \_\_\_\_\_

\_\_\_\_\_

Last TB test? \_\_\_\_\_

History of Communicable Diseases?

- HIV
- HEP C, B, or A
- STD
- MRSA

For checked boxes, please explain current treatment: \_\_\_\_\_

### Legal History

Has the applicant been previously incarcerated?  YES  NO

If yes, what were the charges? \_\_\_\_\_

Does the applicant have a pending criminal charge?  YES  NO

If the applicant is currently incarcerated, where: \_\_\_\_\_

When is the expected release date? \_\_\_\_\_

Charge description: \_\_\_\_\_

Probation requirements:

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Name of probation officer: \_\_\_\_\_

Phone number: \_\_\_\_\_

Has the applicant experienced Intimate Partner Violence?  YES  NO

Is the applicant currently in danger?  YES  NO

Is there a no-contact order in place?  YES  NO

Please be forthcoming with above information as Karis can better support the client if there is full transparency.

### Community Supports

Family Physician: \_\_\_\_\_ Telephone: \_\_\_\_\_

Dentist: \_\_\_\_\_ Telephone: \_\_\_\_\_

Pediatrician: \_\_\_\_\_ Telephone: \_\_\_\_\_

Alcohol & Drug Counsellor: \_\_\_\_\_ Telephone: \_\_\_\_\_

Mental Health Worker: \_\_\_\_\_ Telephone: \_\_\_\_\_

Life Skills Worker: \_\_\_\_\_ Telephone: \_\_\_\_\_

Other Professional Community Supports: \_\_\_\_\_

Is the applicant currently in a relationship?  YES  NO

Are they safe?  YES  NO

Are they sober?  YES  NO

How will that affect the applicant's participation in the program?

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## Cultural Information

How can Karis support the applicant in any cultural, spiritual, or religious practices or ceremonies while at Karis?

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Ethnicity: \_\_\_\_\_

Indigenous Ancestry?  YES  NO

Does the applicant currently have status?  YES  NO

Band: \_\_\_\_\_

## Emergency Contact Information

Name: \_\_\_\_\_

Relationship: \_\_\_\_\_

Phone: \_\_\_\_\_

Address: \_\_\_\_\_

## Substance Misuse History of Treatment

EXPERIENCE WITH	NAME OF AGENCY	DATES	COMPLETE / INCOMPLETE
RESIDENTIAL TREATMENT			
SUPPORTIVE RECOVERY			
DETOX			

If incomplete, please explain: \_\_\_\_\_

## History of Other Misuse

TYPE	DATE LAST ACTIVE	AGE AT FIRST EXPERIENCE
PORNOGRAPHY		
SHOPPING		
SEXUAL		
GAMBLING		
OTHER (e.g. hoarding, shoplifting)		
<b>DISORDERED EATING</b> <input type="checkbox"/> Binging <input type="checkbox"/> Overeating <input type="checkbox"/> Restricting		

## Self-Assessment (strengths, needs, abilities, preferences)

Why is supported recovery the best fit for you? \_\_\_\_\_

In your own words, what are your current challenges to maintaining a sustainable lifestyle?

\_\_\_\_\_

Why have you chosen Karis? \_\_\_\_\_

Are you willing to go into treatment prior to coming into Karis?  YES  NO

What are your expectations for Karis Support Society? \_\_\_\_\_

How long do you expect to be at Karis? \_\_\_\_\_

Are you willing to adhere to the Karis structure while in the program?  YES  NO

What is/are your motivation(s) for maintaining a recovery-based lifestyle?

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**SUBMIT**

Please send all completed applications  
via email to: [applications@karis-society.org](mailto:applications@karis-society.org)  
or fax to: 250.860.9517